



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE FATALITY OF:**

**Jake Harkins**

**Date of Birth: 11/20/03**

**Date of Death: 9/6/13**

**Date of Oral Report: 12/19/13**

### **FAMILY KNOWN or NOT KNOWN TO:**

Philadelphia Department of Human Services

### **REPORT FINALIZED ON**

**3/16/2015**

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.  
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.  
(23 Pa. C.S. 6349(B))

**Reason for Review:**

Senate Bill 1147 Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that County Children and Youth Agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia has convened a review team on January 14, 2014 at 9 am in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<b><u>Name:</u></b>	<b><u>Relationship:</u></b>	<b><u>Date of Birth:</u></b>
Harkins, Jake	Victim child	11/20/03
██████████	Sister	██████████/98
██████████	Mother	██████████/71
██████████	Father	██████████/65
* ██████████	Adult Sister	██████████/89

\* ██████████ resides at another location.

**Notification of Child Fatality:**

Philadelphia DHS received information on 12/19/13 concerning a child homicide which occurred on 9/6/13 that had not previously been reported to them (DHS). Once this information was obtained, the Philadelphia Department of Human Services ██████████ The ChildLine report stated that as a result of a domestic dispute occurring on 9/6/13, ██████████ shot and killed the child while he was lying in bed. ██████████ then shot the mother. ██████████ then committed suicide by shooting himself. The mother survived the assault. ██████████ A ██████████ investigation was initiated by the Philadelphia Department of Human Services on 12/19/13.

**Summary of DPW Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current ██████████ investigative information including the ██████████ as well as supporting written case documentation from the Philadelphia Department of Human Services and the official autopsy report from the Medical Examiner's Office. The Southeast Regional Program Representative also attended the Act 33 meeting on January 14, 2014 where the MDT members met and a thorough case presentation was given.

**Summary of Services to the Family:**

**Children and Youth Involvement prior to the Incident:**

The family had no prior history with DHS.

**Circumstances of the Fatality and Related Case Activity:**

As stated earlier [REDACTED] shot and killed the child while he lay in bed. Previous to shooting the child, [REDACTED] shot the mother before securing himself in the child's bedroom and killing the child. [REDACTED] then committed suicide by shooting himself. A domestic argument with the mother occurred shortly before the shooting. Mother states that she called 911 when she saw [REDACTED] with the gun. When the police arrived outside, [REDACTED] proceeded to shoot her twice in the head and then went into the child's bedroom and shot the child and himself before the police could intervene. It was noted that gun used during the incident legally belonged to the mother and was supposed to be in a locked box. It is unknown how the alleged perpetrator was able to obtain the weapon.

Jake, the victim child was [REDACTED] according to medical reports. [REDACTED]

[REDACTED] Jake was also non-verbal, hearing impaired and had a school history of being bullied. The Coroner's report confirmed that the child died by homicide as a result of 2 penetrating gunshot wounds to the head perpetrated by [REDACTED]

[REDACTED], the AP had a history of [REDACTED] issues and [REDACTED]. [REDACTED] was alleged [REDACTED]

[REDACTED] A statement from mother revealed that [REDACTED] attempted suicide in December of 2011 [REDACTED]

[REDACTED] admits that her [REDACTED] had a history of [REDACTED] issues. At one point the couple separated as a result, but reunited and were living together at the time of the incident. [REDACTED] admits that her [REDACTED] was experiencing paranoia concerning infidelity in their marriage. On the night in question [REDACTED] reports that her [REDACTED] flew into a rage as a result and meant to kill her as well. She also reports that [REDACTED] was "a good [REDACTED] and loved Jake very much."

[REDACTED], the victim child's sibling was also in the home during the incident but was not targeted or physically harmed by the AP [REDACTED] states that the shooting occurred about 1am and that she went into the hallway and saw her mother after she had been shot. She states that she helped her mother call the police. [REDACTED] is currently in [REDACTED]

[REDACTED] is also very close with her mother and has a very supportive school network

which has provided [REDACTED] with much needed emotional support and guidance, and has assisted in helping her to catch up on missed class work.

A [REDACTED] investigation was completed by the Philadelphia DHS on 12/30/13 [REDACTED]  
[REDACTED]

A safety assessment completed at the conclusion of the investigation on 12/19/13 found [REDACTED] to have appropriate parental capacities and her daughter, [REDACTED] to be safe in her care.

**Current Case Status:**

According to the case documentation from the Philadelphia Department of Human Services "at the conclusion of the investigation [REDACTED] (the victim child's sibling) was found to be safe and DHS did not accept the family for services. DHS did confirm that the family was receiving the necessary [REDACTED] social services supports. A closing visit occurred with the family on 12/27/13 which indicated that DHS intervention was no longer warranted.

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Fatality Report:**

**Strengths:**

The County felt that a competent [REDACTED] investigation was completed by the Philadelphia Co. DHS worker (MDT) which included information from the [REDACTED] Police Department and Medical Examiner's office.

The County felt that "case documentation was thorough" and that the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the [REDACTED] investigation.

**Deficiencies:**

The following concerns were identified by the MDT members at the January 14, 2014 Act 33 meeting.

It should be noted that the family was never known to the Philadelphia Department of Human Service and was not opened with the Department at the time of the incident.

Concerns noted during the MDT meeting were first and foremost, focused on the presence of a gun in the home with an adult (and child) with [REDACTED] issues.

There were obvious concerns as to whether [REDACTED] ongoing [REDACTED] issues were being properly and continuously assessed, monitored and treated.

There was discussion as to whether this violent behavior could have been predicted especially given a [REDACTED] that had been secured by the mother in the past.

In the aftermath the team was concerned as to whether the [REDACTED] needs of the family, particularly the adult sibling was being adequately addressed.

Lastly, the Team discussed the need for the inclusion of routine questions, protocols and resources be made available to assess for safety issues such as the presence of firearms, PFAs and vicious animals that could cause a risk to other family members, as well as the social worker.

**Recommendations for Change at the Local Level:** [REDACTED]

**Recommendations for Change at the State Level:** There were no recommendations for change at the state level.

**Department Review of County Internal Report:** The Department has received the County's report dated April 11, 2014 and is in agreement with their findings.

**PA Department of Human Services Findings:** All indications regarding the County's [REDACTED] investigation, medical examiner's reports and a police investigation state that the death of the child occurred due to gunshot wounds to the head perpetrated [REDACTED] and was determined to be homicide and as a result of an intentional attempt to harm the child by the AP. [REDACTED]

**County Strengths:**

The Philadelphia Department of Human Services conducted and completed an appropriate [REDACTED] investigation within 30 days fulfilling all regulatory requirements of the CPSL and Chapter 3490.

**County Weaknesses:**

The Department is in agreement with the deficiencies discussed in the Act 33 meeting and has identified no further weaknesses.

**Statutory and Regulatory Areas of Non-Compliance:** A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

**Department of Public Welfare Recommendations:**

The Department has no further observations or recommendations other than those already contained in the report.